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Payment for Outpatient ESRD-Related Services

Note: Note: This article was updated on April 6 2013, to reflect current Web addresses. This article was previously revised on June 3, 2008, to add a reference to CR5931. CR5931 updates the *Medicare Claims Processing Manual* to reflect requirement changes to the interim billing instructions contained in CR3414. CR5931 may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1456CP.pdf on the CMS website. The related MLN Matters article (MM5931) may be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5931.pdf on the CMS website. All other information remains the same.

Provider Types Affected

Physicians and practitioners

Provider Action Needed

This one-time clarification is provided to assist physicians and practitioners in billing for End Stage Renal Disease (ESRD) related services to patients in hospital observation status and for various partial month scenarios (e.g., partial month without a complete assessment of the patient, patients who have a change in their monthly capitation payment (MCP) physician during the month, and transient patients). Also, clarification is provided for outpatient billing on ESRD-related services when the beneficiary changes modalities during the month (e.g., a home dialysis patient who switches to center dialysis and vice versa).

Background

In the final rule published November 7, 2003, (68 FR 63216) the Centers for Medicare & Medicaid Services (CMS) established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month. Under this methodology, separate codes are billed for providing one visit per month, two-three visits per month and four or more visits per month.

The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four end stage renal disease (ESRD) related visits per month. The G codes are reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

Since changing our payments for managing patients on dialysis, we have received a number of comments from the nephrology community requesting guidance on billing for outpatient ESRD-related services provided to patients in hospital observation settings, transient patients, and in partial month scenarios where the comprehensive visit may not have been furnished. Additionally, questions have been raised regarding the appropriate billing code for patients switching modalities during the month (e.g., from home dialysis to center dialysis).

Therefore, the purpose of CR3414 and this article is to provide immediate, short term guidance as to the appropriate codes physicians and practitioners should use and how Medicare carriers should price claims regarding these specific ESRD-related scenarios.

Policy Clarifications

1. Patients in Hospital Observation Status

General Policy

ESRD-related visits furnished to patients in hospital observation status that occur prior to December 31, 2004, should be coded using the unlisted dialysis procedure code. Physicians and practitioners should use the unlisted dialysis procedure code as described by CPT code 90999 when submitting claims for ESRD-related visits furnished to patients in the hospital observation setting.

Guidelines for Physician or Practitioner Billing and Documentation

In submitting bills for outpatient ESRD-related visits furnished to patients in hospital observation status, physicians and practitioners should include documentation in the medical record describing the type of ESRD-related services provided during the visit. Only one claim should be submitted for all ESRD-related services provided during the visit.

Physicians and practitioners providing ESRD-related visits to beneficiaries in observational status should bill CPT code 90999 outside of the monthly capitation payment (MCP). If the MCP physician furnishes a complete assessment of the patient, he or she may bill the appropriate G code corresponding to the number of visits furnished during the month. However, the visit furnished in the observational setting must be billed separately from the MCP.

Example #1: The MCP physician or practitioner furnishes an ESRD-related visit for a 70 year-old ESRD beneficiary in hospital observation status. Prior to the

ESRD-related visit furnished in the observation setting, the MCP physician furnished a visit for this beneficiary that included a complete monthly assessment and two non-comprehensive visits without a complete assessment at a freestanding ESRD facility. In this scenario, the MCP physician should bill the appropriate two to three visit code, (for example G0318), and CPT code 90999, for the visit furnished to the patient in the hospital observation status.

Example #2: A physician other than the beneficiary's MCP physician furnishes an ESRD-related visit when the beneficiary is in hospital observation status. The MCP physician or practitioner furnishes one visit that included a complete assessment of the patient during the same month. In this scenario, the physician furnishing the visit in the hospital observation setting should bill for the unlisted dialysis procedure code CPT 90999 and the MCP physician should bill for the appropriate one visit monthly capitation code (e.g., G0319).

Guidance for Pricing Claims

The unlisted dialysis procedure code as described by CPT 90999 is carrier-priced. When pricing claims for outpatient ESRD-related visits furnished to patients in hospital observation status, your carrier should consider pricing these ESRD-related visits based on the incremental increase between the one visit MCP code and the two to three visit MCP (e.g., the payment difference between G0319 and G0318).

Example: A 70 year-old ESRD beneficiary is in hospital observation status for two days and is visited once by a physician. The physician bills CPT code 90999 for the ESRD-related visit and payment is based on the difference between G0319 (ESRD related services with one face-to-face visit per month) and G0318 (ESRD related services with two to three face-to-face visits per month). Based on the CY 2004 physician's fee schedule, the RVU's for ESRD-related visits furnished when a beneficiary is in hospital observation status would be 1.36 (6.76 - 5.40 = 1.36).

2. Partial Month Scenarios

General Policy

Partial month scenarios should also be coded using the unlisted dialysis procedure code. Physicians and practitioners should use CPT code 90999 when submitting claims for ESRD-related visits furnished in the following scenarios:

- Transient patients – Patients traveling away from home (less than full month);
- Partial month without a complete assessment of the patient. For example, the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant; or
- Patients who have a change in their MCP physician during the month.

For purposes of this article, the term "month" means a calendar month. The first month the beneficiary begins dialysis treatments is the date the dialysis treatments begin through the end of the calendar month. Thereafter, the term 'month' refers to a calendar month.

Guidelines for Physician or Practitioner Billing

Transient Patients and Partial Month Without a Complete Assessment of the Patient

With regard to transient patients and partial month scenarios (as listed above) the physician or practitioner should specify the number of days he or she was responsible for the beneficiary's outpatient ESRD-related services during the month (e.g., similar to the methodology used for home dialysis patients, less than full month).

Only one code should be used to report the daily management of transient patients and for partial month scenarios. For example, if a transient patient is away from his or her home dialysis site for two weeks, then 14 units of the unlisted dialysis code as described by CPT 90999 is billed.

For transient patients, the physician or practitioner responsible for the transient patient's ESRD-related care should bill CPT code 90999. Only the physician or practitioner responsible for the traveling ESRD patient's care would be permitted to bill for ESRD-related services using CPT code 90999.

For partial month scenarios resulting from hospitalization, kidney transplant, transient patients, or the patient expired, if the MCP physician or practitioner furnished a visit that included a complete monthly assessment of the patient, he or she should bill using the appropriate G code (G0308 through G0319) that reflects the number of visits furnished during the month.

Example #1: A 70 year-old ESRD beneficiary was hospitalized on the tenth through the 20th day of the month. On the third day of the month, the MCP physician or practitioner furnished a face-to-face visit that included a complete outpatient assessment and a subsequent outpatient visit on the 25th day of the month.

While the patient was hospitalized, an inpatient ESRD-related visit was furnished. In this scenario, the MCP physician or practitioner may bill for the appropriate outpatient monthly capitation payment (e.g., G0318). The physician or practitioner who furnished the inpatient visit may bill for the appropriate inpatient ESRD-related service code e.g., the 90935.

Example #2: A 70 year-old ESRD beneficiary vacationing in Florida is away from his or her home dialysis site from August 15 through September 7. On August 10, the MCP physician furnishes a face-to-face visit including a complete assessment of the patient. For the month of September, the MCP physician furnishes a visit

with a complete assessment on the ninth and a subsequent visit on the 25th of the month. A physician in Florida is responsible for the beneficiary's ESRD-related care from August 15 through September 7.

In this scenario, the physician or practitioner responsible for the transient patients ESRD-related care bills sixteen units of the unlisted dialysis procedure code (CPT 90999) for the month of August and seven units of CPT code 90999 for the month of September. The MCP physician bills G0319 (ESRD-related services with one visit) for the month of August and G0318 (ESRD related services with two to three visits) for the month of September.

If the transient beneficiary is under the care of a physician or practitioner other than his or her regular MCP physician for an entire calendar month, the physician or practitioner responsible for the transient patient's ESRD-related care must furnish a complete assessment and bill for ESRD-related services under the MCP.

Patients Who Have a Change in their MCP Physician During the Month

CPT code 90999 should be billed in situations where an ESRD beneficiary permanently changes their MCP physician during the month. For example, the new MCP physician has the ongoing responsibility for the evaluation and management of the patient's ESRD-related care and is not part of the same group practice or an employee of the first MCP physician. The new MCP physician should use CPT code 90999 when submitting claims for ESRD-related services for the remainder of the month, when the first MCP physician furnishes a complete assessment of the beneficiary during the month

If the first MCP physician does not furnish a complete assessment of the patient during the month the patient permanently changes their MCP physician, the new MCP physician may bill for the appropriate G code (G0308 through G0319) and the first MCP physician may bill CPT code 90999 for the partial month as described above.

Example: An ESRD patient residing in Virginia Beach, Virginia for the first 20 days of the month moves to Atlanta, Georgia. As a result, a different physician or practitioner is now responsible for the ongoing management of the beneficiary's ESRD related care. Both the first and second MCP physician furnishes a visit with a complete assessment of the patient and establishes a monthly plan of care. In this situation, the first MCP physician should bill the G code that reflects the number of visits he or she furnished during the month and the second MCP physician should bill CPT code 90999. Thereafter, the new MCP physician would bill for the appropriate monthly capitation payment, e.g., G0318.

In this example, if the first MCP physician does not provide a complete assessment of the patient, he or she should bill 20 units of CPT code 90999 but may not bill for the MCP during the month the beneficiary permanently changes his or her MCP physician. The second MCP physician may bill for the appropriate

monthly capitation payment after furnishing a visit with a complete assessment of the ESRD beneficiary.

Guidance for Pricing Claims

With regard to pricing claims for ESRD-related services furnished to transient patients and the other partial month scenarios as described above, your carrier should consider using the payment amounts for the per diem codes G0324 through G0327. When using these codes, payment is based on the number of days the physician or practitioner was responsible for the beneficiary's outpatient ESRD-related services during the month.

Example #1: A 17-year-old ESRD beneficiary is away from his or her home dialysis site for 2 weeks vacationing in Florida. The physician or practitioner responsible for the transient patient's ESRD-related care should bill 14 units of CPT code 90999. Under the per diem method, payment for CPT code 90999 would be based on G0326 and the RVUs would be 5.74 (.41 x 14 = 5.74).

Example #2: A 10 year-old ESRD beneficiary is hospitalized for 20 days during the month and a complete (outpatient) assessment of the patient for that month was never furnished. The MCP physician should bill 10 units of CPT code 90999. Under the per diem method, payment is based on G0325 and the RVUs would be 3.60 (.36 x 10 = 3.60).

Note: The use of CPT code 90999 is intended to accommodate unusual circumstances where the outpatient ESRD-related services would not be paid under the MCP.

3. Patients Who Switch Modalities During the Month

General Policy

If a home dialysis patient receives dialysis in a dialysis center or other facility during the month, the physician or practitioner is paid the management fee for the home dialysis patient and cannot bill the codes in the range of G0308 through G0319.

This situation should be coded using the ESRD–related services G codes for a home dialysis patient per full month. Physicians and practitioners should use G0320 through G0323 when billing for outpatient ESRD-related services when a home dialysis patient receives dialysis in a dialysis center or other facility during the month.

Example #1: A 70 year-old ESRD beneficiary dialyzes at home for the first 10 days of the month and at a dialysis center for the remaining 20 days. The MCP physician should bill G0323.

Example #2: A 70 year-old ESRD beneficiary dialyzes at a dialysis center for the first 10 days of the month and at home for the remaining 20 days. The MCP physician should bill G0323.

Claims Processing

Carriers will deny claims with G0308 through G0319 when submitted in the same month as G0320 through G0323 for the same ESRD beneficiary. In making the denial, the carrier will generate Remittance Advice (RA) codes B13 and M86.

4. Effective Date and Previously Submitted Claims

These clarifications are effective for claims with dates of service on or after the date of publication CR3414. Your carrier will not reprocess previously paid claims.

Additional Information

To view the entire set of instructions issued to your carrier on this clarification, go to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R300CP.pdf on the CMS website.

If you have additional questions, please contact your carrier at their toll free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.